

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-005147

STATE FILE NUMBER

AMENDED

Registration District No. 336

Primary Registration District No.

Registrar's No.

PLACE OF DEATH

a. COUNTY

Shannon

b. CITY (If outside corporate limits, give TOWNSHIP only)

OR TOWN

Alley Springs, Mo.

Length of stay in 1b

c. FULL NAME OF (If NOT in Hospital, give location)
HOSPITAL OR INSTITUTION

Alley Springs, Mo.

Inside Limits

Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Mo.

b. COUNTY Shannon

admission)

c. CITY OR TOWN

Eminence

Inside Limits

Yes ☒ No ☐

d. STREET ADDRESS

(If outside, give location)

Box 125

Reside on Farm

Yes ☐ No ☒3. NAME OF DECEASED
(Type or print)

First

Middle

Last

Cecil

M.

Mitchell

4. DATE OF DEATH

Month

Day

Year

February

3

1962

5. SEX

M.

6. COLOR OR RACE

W.

7. Married ☒Never Married ☐Widowed ☐Divorced ☐

8. DATE OF BIRTH

3/10/05

9. AGE (last birthday)

56

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HR

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Farming

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country)

Moscow, Mills, Mo.

12. CITIZEN OF WHAT COUNTRY

USA

13a. FATHER'S NAME

Harry Mitchell

13b. MOTHER'S MAIDEN NAME

Laura Archer

14. NAME OF HUSBAND OR WIFE

Sahore Willson Mitchell

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Sahore Mitchell Eminence, Mo. B. 125

18. CAUSE OF DEATH (Enter only one cause per line for

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

NATURAL CAUSES

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

CORONARY THROMBOSIS

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

20a. ACCIDENT

SUICIDE

HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY

Hour a.m. p.m.

Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from _____, to _____ and last saw her/him alive on _____.
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county)

(State)

24. FUNERAL DIRECTOR

ADDRESS

25. DATE RECD. BY LOCAL REG.

26. REGISTRAR'S SIGNATURE

Duncan Funeral Home Mtn. View, Mo.

Huntard W. M. D.

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Charles D. Partain

Licensed Embalmer No. 5107

P. O. Address Wm. W. W. W.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.